Do You Understand the New Medicare Transitional Care Management Service Codes?

Effective January 1, 2013, Medicare and other payers will pay for two new CPT codes **(99495** and **99496**) that are used to report physician or qualifying non-physician practitioner transitional care management (TCM) service for patients, following a discharge from a:

- Hospital
- Skilled Nursing Facility (SNF)
- Community Mental Health Center (CMHC)
- Outpatient observation
- Partial hospitalization

and including a transition to:

- Home
- Domiciliary
- Rest Home
- Assisted Living

These two codes require the medical decision-making to be of moderate to high complexity. Each code encompasses one face-to-face visit and non face-to-face services, for instance, arranging home health agencies for patient care.

Codes are selected based on medical decision-making associated with the patient's condition, the time when the communication is initiated with the patient, and the time when the face-to-face encounter occurs following discharge. The first face-to-face encounter is included. The codes may be reported only once per 30 calendar days. See the full code description at

the end of this article.

The following are FAQs on the codes with answers provided by CMS.

Q: ***What date of service should be used on the claim?***
A: The 30-day period for the TCM service begins on the day of discharge and continues for the next 29 days. The reported date of service should be the 30th day.

Q: What place of service should be used on the claim?
A: The place of service reported on the claim should correspond to the place of service of the required face-to-face visit.

Q: If the codes became effective on Jan. 1 and, in general, cannot be billed until 29 days past discharge, will claims submitted before January 29th with the TCM codes be denied?
A: Because the TCM codes describe 30 days of services and because the TCM codes are new codes beginning on January 1, 2013, only 30-day periods beginning on or after January 1, 2013 are payable. Thus, the first payable date of service for TCM services is January 30, 2013.

Q: The CPT book describes services by the physician's staff as "and/or licensed clinical staff under his or her direction." Does this mean only RNs and LPNs, or may medical assistants also provide some parts of the TCM services?
A: Medicare encourages practitioners to follow CPT guidance in reporting TCM services. Medicare requires that when a practitioner bills Medicare for services and supplies commonly furnished in physician offices, the practitioner must meet the "incident to" requirements described in Chapter 15 Section 60 of the Benefit Policy Manual 100-02.

Q: Can the services be provided in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC)?

A: While FQHCs and RHCs are not paid separately by Medicare under the Physician Fee Schedule (PFS), the face-to-face visit component of TCM services could qualify as a billable visit in an FQHC or RHC. Additionally, physicians or other qualified providers who have a separate fee-for-service practice when not working at the RHC or FQHC may bill the CPT TCM codes, subject to the other existing requirements for billing under the MPFS.

Q: If the patient is readmitted in the 30-day period, can TCM still be reported?

A: Yes, TCM services can still be reported as long as the services described by the code are furnished by the practitioner during the 30-day period, including the time following the second discharge. Alternatively, the practitioner can bill for TCM services following the second discharge for a full 30-day period as long as no other provider bills the service for the first discharge. CPT guidance for TCM services states that only one individual may report TCM services and only once per patient within 30 days of discharge. Another TCM may not be reported by the same individual or group for any subsequent discharge(s) within 30 days.

Q: Can TCM services be reported if the beneficiary dies prior the 30th day following discharge?

A: Because the TCM codes describe 30 days of care, in cases when the beneficiary dies prior to the 30th day, practitioners should not report TCM services but may report any face-to-face visits that occurred under the appropriate evaluation and management code.

Q: Medicare will only pay one physician or qualified practitioner for TCM services per beneficiary per 30 day period following a discharge. If more than one practitioner reports TCM services for a beneficiary, how will Medicare determine which practitioner to pay?

A: Medicare will only pay the first eligible claim submitted

during the 30 day period that commences with the day of discharge. Other practitioners may continue to report other reasonable and necessary services, including other E/M services, to beneficiaries during those 30 days.

Open Door Forum Call Including TCM Code Information

CMS is holding a Open Door Forum on Tuesday, March 12, 2013, at 2:00 p.m. Eastern (ET) which will include some information about TCM codes, and an opportunity for listeners to ask individual questions of the presenters.

CALL AGENDA: (subject to change)

I. Opening Remarks

- *Chair – Stewart Streimer (CM)*
- *Co-Chair – Dr. William Rogers (OPE)*
- *Moderator – Barbara Cebuhar (in lieu of Matthew Brown, OPE)*

II. Announcements & Updates

- *Physician Compare Website Redesign*
- *DMEPOS Competitive Bidding*
- *Ordering & Referring*
- *Transitional Care Management:*
- *Health Insurance Marketplace*

III. Open Q&A

Open Door Participation Instructions:

To participate by phone:

Dial: 1-800-837-1935 & Reference Conference ID: 78871126. Call in 15 minutes before the start of the call.

Persons participating by phone do not need to RSVP

TTY Communications Relay Services are available for the Hearing Impaired. For TTY services dial 7-1-1 or 1-800-855-2880. A Relay Communications Assistant will help.

Encore: 1-855-859-2056; Conference ID: 78871126.

Encore is an audio recording of this call that can be accessed by dialing 1-855-859-2056 and entering the Conference ID. This recording will be accessible beginning 2 hours after the ODF and expires after 3 business days.

99495 – 99496 Management Of Transitional Care Services

These codes include:

- Moderate to high complexity medical decision making needs during care transition
- First interaction (can be face-to-face, by telephone, or electronic) with patient or his/her caregiver and must be done within 2 working days of discharge. If two separate attempts are made in a timely manner, but are unsuccessful and other TCM criteria are met, the service may be reported. Medicare, however, expects attempts to communicate to continue until they are successful.
- Initial face-to-face interaction within described time frame (99495 = 14 days and 99496 = 7 days) and include medication management
- All services from the discharge day up to 29 days post-discharge

Examples of non face-to-face services provided by physicians and non-physician providers included in TCM codes are:

- Arrangement of follow-up and referrals with community

resources and providers
- Contacting qualified health care professionals for specific problems of patient
- Review of discharge information
- Need for follow-up care review based on tests and treatments
- Patient, family and caregiver education

Note that the non-physicians who may bill TCM codes are **Nurse Practitioners (NPs), Physician Assistants (PAs), Clinical Nurse Specialists (CNSs), and Certified Nurse Midwives (CNMs)**, unless they are otherwise limited by their state scope of practice.

Physicians reporting TCM codes are most likely to be **primary care physicians**, however other specialties may report them. Both CPT and Medicare prohibit a physician who reports a service with a global period of 10 or 90 days from also reporting the TCM service.

Examples of non face-to-face services provided by staff under the guidance of physicians and non-physician providers included in TCM codes are:

- Caregiver education to family or patient, addressing independent living and self-management
- Communication with patient and all caregivers and professionals regarding care
- Determining which community and health resources would benefit the patient
- Providing communication with home health and other patient-utilized services
- Support for treatment and medication adherence
- The facilitation of services and care

These TCM codes do not include (and may be billed separately):

- E/M services after the first face-to-face visit
- Tests and procedures

The following services cannot be billed during the time period covered by transitional care:

- care plan oversight services (99339, 99340, 99374 – 99380)
- prolonged services without direct patient contact (99358, 99359)
- medical team conferences (99366 – 99368)
- end stage renal disease services (90951 – 90970)
- online medical evaluation services (98969, 99444)
- education and training (98960 – 98962, 99071, 99078)
- anticoagulant management (99363, 99364)
- telephone services (98966 – 98968, 99441 – 99443)
- preparation of special reports (99080)
- analysis of data (99090, 99091)
- complex chronic care coordination services (99481X – 99483X)
- medication therapy management services (99605 – 99607)

99495 – Transitional Care Management Services (Medicare reimburses $163.99 for non-facility) with the following required elements:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge.
- Medical decision making of at least **moderate complexity** during the service period
- Face-to-face visit within **14 calendar days** of discharge

99496 – Transitional Care Management Services (Medicare reimburses $231.36 for non-facility) with the following required elements:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge.
- Medical decision making of **high complexity** during the service period
- Face-to-face visit within **7 calendar days** of discharge (note that discharge and TCM may not be billed on the same day.)

What questions do you need to answer in your practice to insure you are correctly using the TCM codes?

1. Have you spoken with all payers to determine which ones will reimburse you for TCM codes?
2. If you do not see your patient in the hospital, how will you know your patient is in the hospital? Most hospitals/facilities should call you to schedule a follow-up visit for the patient, triggering a TCM event. If this is not being done, how will you know your patient has been discharged? Hospitals have a vested interest in making this work as they want to prevent readmissions, so they should be helpful in working on a communication plan.
3. Who in your practice has primary responsibility for managing the discharged patients and triggering the

first contact and face-to-face visit within the time frames? What manual or electronic tickler system will be used to alert staff?

4. What forms for a paper chart or templates for an EMR will be needed for documentation of all services provided?
5. Do your providers know the difference between moderate and high complexity medical decision making? If not, get them up to speed.
6. Will your billing system flag the claim with the TCM code to be dropped at 30 days, or will you need an alert system to be sure the claim is dropped appropriately? Can your billing system be programmed to hold charges to review for TCM patients that will not be paid during the TCM period in addition to the TCM code? If not, what's your plan?

Guest Consultant Donna Izor: Behavioral Health & Primary Care Integration: Make Your Practice a Leader

Like other medical conditions, behavioral health issues span the spectrum from mild to significant mental illness (SMI). There are many national studies, such as the **Impact Model**, showing the benefits of identification and treatment of depression in the primary care setting. Many practices have added a mental health clinician or social worker to their

staff to expand on-site care for those needing lower level behavioral health services and to reduce the stigma for patients accessing mental health services. It is care for those with more significant mental illness that becomes challenging to the primary care practice.

What is the relationship of SMI to physical health?

The National Council for Community Behavioral Healthcare reports that 3 out of 5 individuals with a SMI die from a preventable health condition. In general, the life expectancy of a person with SMI is 25 years less than the average population. They have a higher incidence of chronic medical conditions for individuals exacerbated by smoking, obesity, homelessness, and sometimes by the very drugs used to treat their psychiatric condition. There are many reasons for the lack of medical care for these individuals including social isolation, cost, transportation, and inability to "fit in" to a primary care practice culture of focused discussions. **Many use the emergency department for routine care rather than establishing and maintaining a relationship with a primary care practice.**

Barriers to behavioral health services and to primary care for behavioral health patients

From the primary care perspective, it is often difficult to obtain access for patients to specialty behavioral health services. Your patients may be hesitant to follow your recommendation or referral to a psychiatrist or behavioral health professional because of the stigma that still surrounds mental health. Cost may also be an issue as insurance coverage for mental illness is often "carved out" of private insurances and managed separately requiring pre-authorizations

and other steps to access care. Finally, there may be limited access and availability of services for those with Medicaid or without insurance resulting in months before your patient can be seen.

From the behavioral health perspective, the community mental health center (CMHC) may have difficulty obtaining primary care for their clients. Clients may not want to change their life habits to improve their health. Engaging clients in the need for a primary care provider can be difficult and once done, a practice may not be available that will accept the client. These individuals often take longer to move through a visit and may not be able to provide an accurate medical or social history. Your staff may be anxious to have them in your waiting room or to deal with their mental health issues. The needs of these clients can be significant yet the skills of a medical home can benefit these individuals by coordinating their care, reducing the costs to the overall system, and engaging the individual to improve their health.

How collaboration with a CMHC can be a win-win

Collaborating with the Community Mental Health Center (CMHC) provides an opportunity to improve communication and move towards person-centered care where team members work with each other and the individual to provide the best care in the right setting. It has the potential to decrease costs to the overall healthcare system by reducing the number of unnecessary emergency room visits, reducing no show rates and reducing duplication in efforts. Most importantly, it can improve the quality of care for the individual through identification and treatment of chronic conditions, and promotion of preventative services and wellness.

For the past year I have worked with a statewide CMHC network and with medical centers and primary care practices to work

toward bi-directional care. All providers want the best for their patients as well as to improve the overall care of residents in the communities they serve. This shared belief in person-centered care has led to successful collaboration. The group began by improving their referral system and having regular **care management meetings** to discuss shared patients. Education and group meetings have led to more comfort between the systems. Now they are planning to co-locate a primary care nurse practitioner within the CMHC, expand home visits for CMHC clients, and expand the information collected in the CMHC chart to include an up to date problem list and medication list.

Proven steps to successful collaboration:

- Work with the CMHC to **define the needs and the specific barriers to referrals** to and from your office
- **Include providers, clinicians and staff in planning** and understanding their new roles, processes and procedures
- Openly **discuss the cultural differences** between the health systems and how the organizations can work together to maximize the value of the services offered
- **Establish regular meetings** to discuss shared clients (with proper consents) to assure collaboration and reduce duplication in care management
- **Script discussion points** for patients you are referring to the CMHC to reduce the stigma associated with care and encourage their engagement
- **Establish clear expectations for access**, defining what information is needed for a referral, and developing systems to share information after the visit to and from the CMHC
- **Provide educational materials** on chronic conditions and wellness at the CMHC and offer care opportunities such as flu clinics and health fairs at their site for their clients
- **Educate your staff** to the needs of individuals with SMI

- Ask the CMHC for their help in **managing clients with disruptive behavior** or assist the client in making and coming to scheduled visits
- Be open to learning more about management of individuals with SMI and **managing their drugs** through a collaborative relationship with the psychiatrist
- **Seek support for your actions** through State Offices of Primary Care, AHEC, FQHC, and State Department of Health resources

There are many excellent web sites and articles that can provide additional information and options for integration. These include the **National Council for Community Behavioral Healthcare** and **SAMHSA** (Substance Abuse and Mental Health Services Administration). I encourage you to research the options and begin the process of integration for the benefit of your patients, your practice and your community.

Donna Izor, MS, FACMPE *has more than 20 years of experience as a medical practice executive working with academic, community hospital and private practices, and local and state organizations. Izor's background included responsibility outpatient practices, inpatient physicians, and the development and management of a hospitalist program. Her scope included the authority to plan, lead and direct operational evaluation and improvement, financial management, and regulatory compliance and quality.*

Donna founded West Pinnacle Consulting, LLC where she offers a variety of consulting services including project management, executive support, leadership coaching, quality and performance improvement, provider relations, physician and hospital integration, training, facilitation and practice operations. Her activities include research, reporting and presentation on the bidirectional model of care for local stakeholder, policy maker and statewide audiences and work

with community mental health centers, hospital systems, practices and statewide organizations on primary care and behavioral health integration. She can be reached at (802) 734-6384 or at dizor@westpinnacle.com.

Patient Collections Basics Part 3: Developing a Financial Assistance Program

If you've read parts **1 (Know Your Payers)** and **2 (Implementing Your Financial Policy)** of this series, you are ready to consider a financial assistance policy for those patients without insurance.

Patients without insurance fall into one of three categories:

1. Patients without insurance who have the ability to pay their medical bills but refuse to pay them.
2. Patients without insurance who have the ability to pay their medical bills and are willing to do so.
3. Patients without insurance who do not have the financial resources to pay their medical bills.

Patients in category #1 are easy to identify. We've all encountered them and we know that they do not value what the physician or care provider offers, or they believe that for some reason they should not be required to pay. They will

waste your valuable time and should be discharged from your service if possible.

Patients in category #2 are also easy to identify. They value the healthcare services provided to them and want to pay for them. Depending on your fee schedule, you may want to offer two levels of discounts to patients without insurance.

The first discount is for a patient who does not have insurance and can pay something at time of service, but cannot pay their bill in full. The second discount is for a patient who does not have insurance and can pay their bill in full with a deep discount. That deep discount can be justified by the significant reduction of overhead when no additional work is required to collect the account (e.g. file the insurance, post the payment, send the patient a statement, etc.) **If you know what providing services cost you, you are able to set these two discounts based on the unique cost of your services.**

A quick and dirty way to find out the cost of services in your group is to take the total expenses from your last fiscal year and divide them by the total RVUs produced during the same period, resulting in a cost per RVU. (See Example A) Once you know your cost per RVU, you can multiply it for each service/code and compare it to your retail fee schedule to determine what your discounts should be. (See Example B) It would not be unusual for a medical practice to give uninsured patients a 25% discount off the retail fee schedule, and uninsured patients paying in full a 50% discount, but as each healthcare entity sets its fees using a different methodology, every group should calculate their discounts individually.

Example A		
Expenses YTD 2010	RVUs YTD 2010	Cost per RVU

$1,500,000	30,000	$50.00			
Example B					
Code	RVUs	Cost of service	Fee	25% discount	50% discount
Level 3 Est. Pt.	2.03	$101.50	$150.00	112.50	$75.00

The patients in category #3 are those that are unable to pay even when offered the discounted rates. These patients will need a sliding scale financial assistance program, but there are philosophical and financial questions to be answered before you undertake the creation of a formal program.

Questions to Be Answered By Your Group:

- Do patients in your service area have other care options? Is there a Federally Qualified Health Clinic (FQHC) in your area that offers sliding scale payments? Is there a Free Clinic, or a hospital-sponsored clinic or urgent care? Is there a network of specialists that rotate the responsibility for providing care for uninsured, poverty level or indigent patients? What is your group's responsibility for providing care to uninsured people in the community?
- Can your group afford to give care for less than it costs?
- Will the group limit the number of patients it will see under your financial assistance plan to control the deficit?
- Does your group feel that it is already providing charity care service by accepting Medicare or Medicaid?
- Would your providers rather provide charity care by

volunteering at a local free clinic or going on medical missions?

If your group decides to implement a financial assistance program, here are the steps to take.

1. **Determine the objective of the program,** which might be something like:
    - *The goal of the ABC Clinic's Financial Assistance Program is to provide healthcare services at no charge or at a nominal charge to patients whose annual income is at or below the Federal Poverty Guidelines, and to provide healthcare services at discounted fees to patients whose income is above the Federal Poverty Guidelines but does not exceed ___% of the Guidelines.*
2. Create a financial assistance application that the patient will complete. Your local hospital or social service office may be able to offer their application for you to tweak.
3. Check your state to see if there is a program for patients where insurance is available for a fee that your group might be willing to pay on behalf of the patient. This is typically only worthwhile for large hospital, procedure or surgery fees.
4. Determine what services will and will not be eligible for the program. Visits? Labs? Procedures? Tests? Vaccines? Surgery? Therapy?
5. Determine for what period of time you will grant financial assistance to patients. One month? Six months? One year?
6. Determine what information you will require patients to supply so you can decide upon the appropriate discount. Some standard information to require on a Financial Assistance Application is:
    - Photo Identification

- Check stubs from previous three months
- Check stubs from Social Security
- Check stubs from Disability
- Most recent tax return or W-2s
- Most recent copy of bank statement
- If no income, description of how lodging, meals and utilities are paid
- If federal assistance, copy of paperwork
- If assistance from family or friend, letter describing circumstances
- Check Medicaid status, or ask for copy of Medicaid denial
- Is the patient eligible for insurance at work or under COBRA?

7. Determine what discount you want to apply to what level of the Federal Poverty Guidelines, which you will find on the Internet. Note that the guidelines have not changed for several years.
8. Calculate the discount as follows:
    - Calculate yearly income of patient based on documents supplied (wages + other income) for 12 months + checking/savings amount.
    - Calculation should compare generally to recent tax return or patient should explain any discrepancy.
    - Place the patient in a column on the Federal Poverty Guideline based on their income to determine eligibility for financial assistance.
9. Decide upon the workflow for the financial assistance program – how will you let patients know it is available? Once patients have been approved, how will you identify them and the note the applicable discount in the computer system? How will you keep track of which patients need to reapply to keep their financial assistance programs going?
10. Write your financial assistance policy and follow the policy in the same way for every patient that applies for the program. Keep clear and complete documentation

on each patient who applies.
11. Educate all staff and providers on the policy.

Collections Basics – Part 1: Know Your Payers

In a traditional healthcare setting, the revenue cycle begins with the insurance companies who pay the majority of the bill. There are multitudes of payers and each payer can have many plans. How can a healthcare organization catalog this information, keep this information updated and make this information easily accessible to staff so they can discuss payments with patients in an informed and confident way?

Start by breaking your payers into five main categories as a logical way to organize the data.

1. Payers with whom you have a contract
2. Payers with whom you do not have a contract
3. State and Federal government payers (Medicare, Medicaid, TriCare)
4. Medicare Advantage payers
5. Patients

Payers with whom you have a contract

Your organization has signed a contract with a payer and you have agreed to accept a discounted fee called an allowable, and to abide by their rules. What is the information you need to collect?

- A copy of the contract
- A detailed fee schedule, or a basis for the fees, such

as “150% of the 2008 Medicare fee schedule.”

- Any information about the fees being increased periodically based on economic indicators, or rules (notification, timeline, appeals) on how the payer can change the fee schedule.
- The process and a contact name for appealing incorrect payments.
- Information on what can be collected at time of service. Hopefully your contract does not have any language that prohibits collections at time of service, but you must know what the contract states.
- Process for checking on patients’ eligibility and benefits: representative by phone, interactive voice response (IVR), website or third-party access.

The contract allowables should be loaded into your practice management system so you can calculate the patient’s responsibility at check-out and you can identify incorrect payments at the time of check-posting. If your practice management system does not have this feature, you will need a cheat sheet for each contracted payer, showing the most common services, the allowables, and the percentages of the allowables for fast calculation of the patient’s portion at check-out. The same or a modified cheat sheet will work for the check posters so they can verify the payer is reimbursing according to the contract.

Your cheat sheet should look like this:

Plan A							
Service	Allowable	20%	40%	50%	60%	80%	90%
99213	75.00	15.00	30.00	37.50	45.00	60.00	67.50

The check-out staff will write the patient’s portion on the encounter form (you may call it a charge ticket, fee ticket, rounding slip, or superbill), add the numbers together and give the patient the total. Alternately, the computer system will total the patient’s portion based on the payer and the

plan for the check-out person.

The balance of the information collected will be used to develop a payer matrix that might look something like this:

Payer	Employers	Collectible At TOS	Elig/Benefit Verification	Plan Year	Contract Dates	How to Notify
XYZ	WalMart	Deductible & Co-Pay	website	July-June –	Exp Dec 2013, must neg. <Aug1, 2012	Call June Jones at 1-800-555-1212
	State Employees	Deductible & Co-Ins.	Website	Jan –Dec	same	same

Another excellent way your organization can catalog payer and plan information is electronically in a document management system such as **FileConnect,** which I use and recommend.

FileConnect is an electronic filing cabinet with many great attributes, one of which is particularly helpful in this scenario. Every time there is a change in a payer contract, or a new plan is added by a local employer, you can update the staff's spreadsheet tools simultaneously and the newest version will be instantly available on their desktops.

Payers with whom you do not have a contract

Your primary payers in your community or region will most likely offer you a contract. Payers with less covered lives will not find it worthwhile to contract with healthcare providers, so you must decide how you will work with these companies and with these patients.

You are not required to file claims with payers that you are not contracted with. Most healthcare providers do file claims with non-contracted payers to ensure patient satisfaction. Where providers may differ, however, is whether or not they will ask patients with non-contracted payers to pay in full at

time of service, and assign the payment to the patient OR ask the patient to pay only the expected patient portion at time of service and assign the payment to the provider. This decision will be made as part of your Financial Policy (covered in Part 2.)

State and Federal government payers (Medicare, Medicaid, TriCare)

There has been a tremendous discussion in healthcare for the last several years about physicians limiting how many Medicare patients they will see, or even discontinuing to see Medicare patients completely. The rate at which Medicare pays is not enough to support the provision of services in most ambulatory practices, so some physicians do not participate in the Medicare program but still see Medicare patients (the fee they can charge Medicare patients is federally controlled and is called the "limiting" charge) or have opted out of the Medicare program altogether and will see Medicare patients on a cash basis only.

If a practice does accept Medicare patients, whether participating or not, there are set amounts to be collected from patients with Medicare – deductibles and co-insurance, as well as services that are never covered by Medicare.

Make sure that current Medicare allowables for your locality are loaded into your computer to do the math for you. You can use the same type of spreadsheet shown above to develop a cheat sheet of 80% of the Medicare allowable.

Service	Medicare Allowable	20% Owed by Patient
99213	66.74	13.34

What is confusing to most providers is what an insurance that is secondary to Medicare will pay. Many providers do not collect any fees at time of service for Medicare patients with

a secondary payer, as there may or may not be any balance left that is the patient's responsibility.

Medicaid pays less than Medicare does, and based on the very low fee schedule, many ambulatory providers will not accept Medicaid patients. Many Medicaid patients must depend on health departments, hospital clinics, federally-qualified health centers (FQHCs) and rural health clinics (RHCs) for care.

Tricare may be accepted on a case-by-case basis. A healthcare provider does not need to accept the health insurance for retired military across the board, and may decide individually whether to accept a Tricare patient or not.

Medicare Advantage

Medicare Advantage Plans, formerly called Medicare Choice + and now called Medicare replacement plans or Medicare Part C, are plans offered by non-government payers which replicate Medicare benefits for seniors, sometimes offering enhanced benefits as part of the package. There are several types of Medicare Advantage Plans, but the main types are local or regional HMO plans which require you to sign a contract, and the Private Fee For Service Plans (PFFS), for which no contract is required. If you see a Medicare Advantage PFFS patient, you have in essence agreed to accept their terms. The one thing you should ask prior to accepting a Medicare Advantage PFFS plan/patient, is what percentage and what year of Medicare rates are they paying.

Patients

So we finally arrive at the payer with whom most healthcare entities have the most difficulties – the patient. Why is it so difficult to collect from patients?

First, as we have seen throughout this article, insurance can

be very confusing. Without a plan for organizing and sharing information, a healthcare provider may have significant difficulty assessing the patient's payment responsibility.

Second, it has been a cultural norm until recently that patients do not have to pay at time of service, with the exception of their co-pay, and will be billed for their portion after insurance pays.

We know now that we must collect the correct payment at time of service. This is the only way to reduce the administrative expense of billing the patient for the balance and/or refunding the patient if too much has been collected. This is also the only way to maintain adequate cash flow as much of what used to be paid to the providers from insurance companies has now become the responsibility of the patient. Higher co-pays, higher co-insurance and most of all, extremely high deductible plans have left patients owing much more out-of-pocket and largely being unprepared to pay it at time of service.

In the next part of this series, Collections Basics Part 2: Develop Your Financial Policy, we will discuss setting up your financial policy so both patients and your staff can understand it, and how to collect from patients according to your policy.

Robert Anthony from CMS Takes Questions on Stage One

Meaningful Use in PhysiciansPractice Webinar

Today, **PhysiciansPractice** sponsored a webinar with CMS's Robert Anthony on the topic of "Meaningful Use Stage 1." Robert Anthony is a Health Insurance Specialist in the Office of E-Health Standards and Services (OESS) at the Centers for Medicare & Medicaid Services (CMS), where he focuses on the EHR Incentive Programs. Robert had a very pleasant voice to listen to, and he gets my vote for the best CMS Employee Speaker that I've heard!

I was not familiar with the OESS before, so I looked it up and found out what they do: **Provide the overall leadership for and coordinate the implementation of Title IV of the HITECH Act. (Title IV = Medicare and Medicaid Health Information Technology)**

Robert briefly reviewed what has happened to date with the EHR Incentive Program and the terms of the Medicare and Medicaid programs. The three main differences in the two programs are:

1. The **types of provider**s that are eligible for each program – information **here.**
2. The **volume of each type of patient** needed to participate: no volume needed to participate in the Medicare program and 30% Medicaid patients for all eligible practitioners except pediatricians who only need 20% Medicaid patients.
3. The **tasks in year one** in which the certified EHR is adopted. For Medicaid the practice only needs to attest that they have adopted, implemented or upgraded an EHR. In year one for Medicare the practice needs to attest to meaningful use for 90 days, which means data is collected and input into the attestation system.

The majority of the webinar was devoted to FAQs (my favorite

part of any CMS-related education session!)

FAQs

Q: Can entities participate in the Medicare EHR Demonstration Project, and the Medicare or Medicaid EHR Incentive programs too?

A: Yes. The demonstration projects are about to be sunsetted (completed.)

Q: What information must be provided to patients to meet the requirement for a clinical summary at the end of each visit?

A: If system is certified, it will automatically provide the appropriate information for the clinical summary, which includes the patient's problem list, medication list, medication allergy list, and diagnostic test results.

Robert suggested looking at the answer online at the CMS FAQ which I posted below:

In our final rule, we defined "*clinical summary*" as: an after-visit *summary* that provides a patient with relevant and actionable information and instructions containing, but not limited to, the patient name, provider's office contact information, date and location of visit, an updated medication list, updated vitals, reason(s) for visit, procedures and other instructions based on *clinical* discussions that took place during the office visit, any updates to a problem list, immunizations or medications administered during visit, *summary* of topics covered/considered during visit, time and location of next appointment/testing if scheduled, or a recommended appointment time if not scheduled, list of other appointments and tests that the patient needs to schedule with contact information, recommended patient decision aids, laboratory and other diagnostic test orders, test/laboratory results (if received before 24 hours after visit), and

symptoms.

The EP must include all of the above that can be populated into the *clinical summary* by certified EHR technology. If the EP's certified EHR technology cannot populate all of the above fields, then at a minimum the EP must provide in a *clinical summary* the data elements for which all EHR technology is certified for the purposes of this program (according to §170.304(h)):

- Problem List
- Diagnostic Test Results
- Medication List
- Medication Allergy List

Q: How and when are incentive payments made?

A: After the online attestation is made (attestation thresholds must be attained), provider information is verified, then in 6 to 8 weeks a payment is generated. Payments are made in whatever way the entity typically gets CMS payments.

***Q: What if patients do not routinely receive prescriptions during an office visit? How can the threshold be met*? (Referring to computerized provider order entry (CPOE) for medication orders.)**

A: For attestation, practices need to do this for 30% or more of all unique patients with at least one medication in their medication list. Note that patients with no medications in their medication list are excluded, so CMS believes this core initiative is realistic.

Q: For the Medicaid program, do you count the patient visit or the number of services (e.g. patient visit plus two tests equals three patient ticks) during the visit?

A: This question needs follow-up and if you send an email to

editor@physicianspractice.com, they will be sent to CMS for the answer. Here is additional information from the CMS FAQ:

> ***When calculating Medicaid patient volume or needy patient volume for the Medicaid EHR Incentive Program, are eligible professionals (EPs) required to use visits, or unique patients?***
>
> *There are multiple definitions of encounter in terms of how it applies to the various requirements for patient volume. Generally stated, a patient encounter is any one day where Medicaid paid for all or part of the service or Medicaid paid the co-pays, cost-sharing, or premiums for the service. The requirements differ for EPs and hospitals. In general, the same concept applies to needy individuals. Please contact your State Medicaid agency for more information on which types of encounters qualify as Medicaid/needy individual patient volume.*

Q: We are a new practice and plan on getting an EMR in the next 3 months. Can you walk me through the time lines?

A: If you haven't chosen an EMR yet, your first year in either program will probably be 2012. In the first year of Medicare participation, you will need to use the EMR meaningfully for 90 days during calendar year 2012, and you have up to 60 days after the close of the calendar year to attest to your use. In the first year of Medicaid participation, you will need to adopt (acquire, install), implement (commence utilization of EHR such as train, data entry), or upgrade (expand) a certified EHR and attest to your activity at any time during the calendar year.

Q: What validation or oversight will CMS provide for the attestation process?

A: Before any payment is made, checks of provider eligibility and information will be done. Keep in mind that attestation is

a legal process. Random audits will be put in place in the near future.

Q: ***Should a practice register if we don't know which program we are going to use?***

A: You can register at any time, and you can change from one program to the other prior to attesting, so you can register for one program and change before you begin the attestation.

Q: If your first year of attestation is in 2012, can you get the full 44K over the course of the program?

A: Yes.

Q: Can you verify if Physician Assistants are eligible for one of the programs?

A: Physician Assistants (PAs) are only eligible under the Medicaid program and must be the lead provider for a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) to qualify.

Q: Does a radiology practice have to provide a clinical summary for patients?

A: No practice type is excluded from clinical summary mandate. CMS has not heard of any practice type having a problem with this so far. Remember, to achieve meaningful use, you must provide clinical summaries to patients for more than 50 percent of office visits within three business days. **Exclusion: Any EP who has no office visits during the period of EHR reporting.**

Q: Is the problem list supposed to be related to the chief compliant of the office visit?

A: Not necessarily. Practices are required to maintain an up-to-date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT (Systematized Nomenclature of Medicine –

Clinical Terms) codes. To comply, at least 80 percent of all unique patients seen by eligible providers must have at least one entry (**or an indication of none**) recorded as structured data.

Q: What if questions were not able to be answered during the webinar?

A: Please **e-mail** Physicians Practice and we'll get your answers from CMS. This could take several days, so please be patient. We will post your answers and all post-webinar questions at **http://www.physicianspractice.com** and notify you via e-mail as well.

Resources

A great list of additional resources were provided by Robert Anthony and Physicians Practice:

Resources from CMS

- **EHR Incentive Programs website**
- **ONC website**
- **FAQs**
- **Listserv**
- **Meaningful Use Specification Sheets**
- **EHR Information Center**
- **Registration & Attestation User Guides**
- **EHR Hotline:** 888-734-6433 / -6563 (TTY)

Resources from PhysiciansPractice.com

- Topic Resource Centers
  - **EHR**
  - **Meaningful Use**
- Tools
  - **Are You Ready? Quiz**
  - **Pricing Worksheet**
  - **Preparation Checklist**

    - Meaningful Use Stage 1 Crib Sheet
- *You can also listen to an archived video of today's webinar here.*

Other Posts I have written on this topic:

Step by Step Directions for Getting the EHR Incentive Money: My Notes From Last Week's CMS Call

CMS Holds National Provider Calls for the Medicare EHR Incentive Program and EHR Attestation Q & A

Digging Into the Details of "Certified EMR" & Tips For Buying an EMR

How Do You Get That Stimulus Money for Using an Electronic Medical Record? (You Register!)

How My Practice Knew We Were Ready for EMR

10 Ways to Get More Out of Your PM, EMR or Any Medical Software

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Step by Step Directions for Getting the EHR Incentive Money: My Notes From Last

Week's CMS Call

First the facts on what has taken place so far in the 2011 EHR Incentive Programs.

- As of June 30th, the total of ***Medicare*** EHR Incentive Program payments is over $94 million.
- As of June 30th, over $166 million has been paid in ***Medicaid*** EHR incentives since the program began in January. In May and June, four states launched Medicaid EHR Incentive Programs – Indiana, Ohio, Pennsylvania, and Washington, bringing the total states with Medicaid EHR Incentive Programs to 21. More states will launch in July.
- There are 68,001 active registrations of eligible professionals and eligible hospitals for the Medicare and Medicaid EHR Incentive Programs.

If your group hasn't received a check and hasn't registered for the Medicare or Medicaid Incentive Program, then this blog post is for you! For anyone who is really just beginning their EHR journey, today's presentation clarified previous information given by CMS, as well as giving listeners new information about the programs.

The two primary steps to obtaining incentive payments are:

1. **Register** for the EHR Incentive Program
2. **Attest** to meeting all the incentive payment eligibility criteria

Let's start with information on the two different incentive programs. Remember that an eligible professional (EP) is defined differently for Medicare than it is for Medicaid.

Step One: Are You Eligible for the EHR Incentive Programs?

Medicare Eligible Professionals:

- Must be a physician (defined as MD, DO, DDM/DDS, optometrist, podiatrist, or chiropractor) – mid-levels do not qualify
- Must have Pa rt B Medicare allowed charges
- Must not be hospital-based which is defined as having 90% or more of their covered professional services in either an inpatient (POS 21) or emergency room (POS 23) of a hospital
- Must be enrolled in PECOS
- Must be living (Social Security records are examined)

Medicaid Eligible Professionals:

- Must be a MD, DO, DDM/DDS or a Nurse Practitioner, a Certified Nurse Midwife, **OR** a Physician Assistant who is the lead provider for a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC).
- Must either have 30% or more Medicaid patient volume (pediatricians must have 20% or more Medicaid patient volume) **OR** must practice predominantly in a FQHC or RHC with 30% or more needy individual patient volume. Needy is defined as patients who are Medicaid, Medicare, uninsured, under-insured, charity care and indigent care.
- Must be licensed and credentialed
- Must have no OIG exclusions
- Must be living (Social Security records are examined)
- Must not be hospital-based, which is defined as having 90% or more of their covered professional services in either an inpatient (POS 21) or emergency room (POS 23) of a hospital

Step Two: How much EHR Incentive Money is Available From the Two Programs?

Medicare Incentive Payments:

- First eligible year for the program is 2011.
- Incentive amounts are based on the EP's Medicare Fee-for-Service allowable charges.
- Maximum incentives are $44,000 over 5 years.
- Incentives decrease if the EP does not start until after 2012.
- EPs must begin using an EHR by 2014 to receive incentive payments.
- Last payment year is 2016.
- An extra 10% bonus amount based on actual payments from Medicare, not allowables, is available for EPs practicing predominantly in a Health Professional Shortage Area (HPSA). **Go here to see if you practice in a HPSA.**
- EPs will receive only 1 incentive payment per year.

Medicaid Incentive Payments:

- First eligible year for the program is 2011.
- Maximum incentives are $63,750 over 6 years.
- Incentives are the same regardless of the year started.
- The first year's payment is $21,250.
- Must begin by 2016 to receive incentive payments.
- No extra bonus for health professional shortage areas.
- Incentives are available through 2021.
- EPs will receive only 1 incentive payment per year.

How Do You Choose Which Program to Qualify For?

1. First, determine which programs you can qualify for based on the **type of eligible professional** you are.
2. Then, determine which programs you can qualify for based on **your patient population**.
3. Next, review the **requirements and potential payments and/or reductions** for each program – get your calculator out!
    - Once an eligible professional has demonstrated meaningful use in the first participation year, they may receive an incentive payment equal to 75% of Medicare allowable charges for covered professional services furnished by the eligible professional in a payment year **VERSUS** Once an eligible professional has demonstrated adoption, implementation, upgrading, or meaningful use of certified EHR technology in the first participation year, they may receive an incentive payment of $21,250 from Medicaid. Remember the payments are for each provider. Don't forget the 10% HPSA bonus if you participate in the Medicare program.
    - Medicare requires EPs to escalate meaningful use participation and reporting and ultimately plans to impose payment reductions for EPs not engaged in using a certified EHR and implementing meaningful use. For Medicaid, each state has some leeway is defining the criteria for eligibility for incentives and there are no plans for payment reductions as a part of the program.
4. If you not up to speed on meaningful use and want to collect incentive money for 2011, it will be easier to

you to meet the requirements of the Medicaid program than the Medicare program, if you are eligible for the Medicaid program and there is one offered in your state.
5. Remember that EPs can switch programs once after their first year in either program.

Getting Ready for the Registration Process

1. Make sure you have your provider's **National Plan and Provider Enumeration System (NPPES)** User ID and Password. If the provider does not know this information, s/he will have to call and get the information. **The NPI, NPPES User ID and password are the basis for everything else.** While you're in that record, make sure all the provider's information is correct and completely up-to-date. You'll have an opportunity to update this information during the registration process, but it will not backfill the NPPES record.
2. Make sure your provider's enrollment record in the **Provider Enrollment, Chain and Ownership System (PECOS).** You can see if s/he has a record in PECOS here – scroll down this page to "OrderingReferringReport". This is a 16,000+ page pdf file and as of this post it was updated June 27, 2011. (Note: Eligible professionals who are only participating in the **Medicaid** EHR Incentive Program are not required to be enrolled in PECOS.)
3. If you do not have an active User ID and Password for NPPES or PECOS, request them via **Identity & Access Management**. You will need your type 2 NPI, your Taxpayer Identification Number (TIN), and your address from IRS Form CP-575. You will also need to mail a copy of IRS Form CP-575 as directed.
4. Payee Tax Identification Number (if you are reassigning

your benefits to a group or a hospital).

5. Payee National Provider Identifier (NPI) if you are reassigning your benefits. Note that many independent physicians are reassigning their benefits to their practice and almost all hospital-sponsored physicians are reassigning their benefits to the hospital.

Step by Step Directions to Register for the Medicare/Medicaid EHR Incentive Programs

NOTE! You can register before you have a certified EHR. Register even if you do not have an enrollment record in PECOS which is required for all Medicare eligible professionals. If you plan to register for the Medicaid program, your state's Medicaid program must be up and running. Check to see if your state has launched a Medicaid EHR Incentive Program here.

1. Go to the **registration site here**. The Login page instructs the user on what is required for a valid User ID and Password combination. EPs are required to have an active NPI and must have a National Plan and Provider Enumeration System (NPPES) user account to login. For users who do not have either of these requirements, click on the link provided to you in the program.
2. A link to the Identity and Access Management System, I&A, is also provided. The I&A system allows EP users use to reset their passwords and edit their account information. Any additional login issues can be resolved by contacting the help desk (see info at the bottom of this post.) At the bottom of the page the user enters their User ID and Password combination. Please keep in mind that both of the fields are case-sensitive.
3. Once the user has logged into the system, the links and

tabs displayed in the top right hand corner are shown on every page.

- The **Home** hyperlink navigates the user to the Welcome page.
- The **Help** hyperlink opens a PDF User Manual that assists the user throughout the Registration process.
- If at anytime you wish to logout of the system, click the **Log Out** link and select yes in the pop-up window.
- The **Instructions** section on the Welcome page describes the actions that can be performed under each of the tabs. The EP submits and maintains their registration under the Registration tab and completes their Attestation under the Attestation tab.
- The **Status Tab** provides a snapshot of the user's current standing in the EHR Incentive Program. This includes the status of their registration and any attestations and payments associated with their account.
- The **Account Management** tab allows the user to proceed to the I&A system in order to change their account information.
- Clicking the **Registration** tab will reveal a set of instructions about the actions that can be performed. These options will differ depending on the status of the registration.

4. The EP's name, social security number, and NPI are retrieved from their NPPES account. If they have not started their registration, the status will be blank and **Register** will be the only available action.
5. Select the **Register** link to begin.
6. The Registration ID is displayed on the "Topics for this Registration" page. **Write this number down** for tracking purposes.
7. There are three topics that an Eligible Professional

must complete before submitting their Registration. They are EHR Incentive Program, Personal Information, and Business Address and Phone. The "Begin Submission" button cannot be selected until all of the topics are complete. Select the **"Start Registration"** button to navigate to the first topic.

8. On the EHR Incentive Program page, EPs are given the option to receive either a **Medicare or Medicaid EHR Incentive Payment**. For additional information about the two EHR Incentive Programs select the link that is provided. By selecting the Medicare option and clicking the "Apply" button, the EP type field page cursor moves across screen to highlight information. Provider Types that are eligible in the Medicare EHR Incentive Program are displayed in the dropdown. Selecting the Medicaid option and then the "Apply" button refreshes the page with two fields, Medicaid State/Territory and Eligible Professional Type. Only those states and territories participating in the Medicaid EHR Incentive Program are displayed in the Medicaid State/Territory dropdown. Provider types that are eligible for the Medicaid EHR Incentive Program are displayed in the dropdown.
9. Two additional links on the EHR Incentive Program page provide the user with information on certified EHRs and the EHR Certification Number. The Eligible Professional is required to indicate whether they are currently using a certified EHR.
   A provider's EHR system is not required to be certified prior to registration; however, an EHR Certification Number will be required at the time of attestation. See the **Certified Health IT Product List (CHPL)** for a listing of "certified" EHR products and to identify a product's corresponding certification number.Select the "Save and Continue" button to navigate to the next topic.
10. The Name and Identifiers displayed on the Personal Information page are retrieved from the user's NPI

record on the NPPES system. These fields cannot be modified in the EHR Incentive Program System. The Payee TIN Type field provides the user with two options in terms of who receives the EHR Incentive Payments. If the payments should be sent directly to the Eligible Professional, the SSN tab should be selected in the Payee TIN Type field. If the payments should be sent to a group associated with the Eligible Professional, the user should select E-I-N in the Payee TIN Type field and then select the "Apply" button. After the page is refreshed, three additional fields are displayed.

11. The next step is to select the Group that should receive the payments. A Group Name will only appear in the dropdown if the EP's Medicare enrollment in the Provider Enrollment, Chain, and Ownership System, or PECOS, has reassigned benefits to the Group. After the Group Name is selected, the Group's TIN is retrieved from PECOS and displayed in the Payee TIN field. It is also required that the user enters the NPI associated with the Group in the Payee NPI field. If the user had selected to register for the Medicaid EHR Incentive Program, the system requires the user to manually enter the Group Name, Payee TIN, and Payee NPI. A dropdown list of Group Names would not be provided. Select the "Save and Continue" button to navigate to the next topic.
12. The address and phone number displayed on the Business Address and Phone page is consistent with the Practice Location on the Eligible Professional's NPI record. Unlike the Personal Information page, the address and phone number fields can be modified here. However, if changes are made to the address and phone number in the EHR Incentive Program System, the changes will not be reflected on the Eligible Professional's NPI record. E-mail Address is also a required field and must be entered with the correct email address format. Select the "Save and Continue" button to complete the last topic.

13. Once the user has entered the required registration information, all three of the topics are marked as completed. To initiate the submission process, select the “Begin Submission” button.
14. The Verify Registration page displays a summary of the registration information. It displays Personal Information, Business Address, as well as the Incentive Program that was chosen for this registration. The “Reason for Submission” section describes the action that the user is currently performing on the registration. If any of the information on this page is incorrect, the user should select the “Previous Page” button and make the appropriate modification.
15. After verifying that all of the information is correct, please select the “Submit” button to proceed. Before the registration can be submitted, the user must review and agree to the Registration Disclaimer. Agreeing to the legal notice means that the EP is certifying that the information provided in the registration is true and accurate. Please take the time to review each line of the disclaimer. Select the “Agree” button to proceed.
16. If the registration passes all validations, the submission will be successful. Please keep in mind that things like a non-approved Medicare enrollment in PECOS or OIG Exclusions can result in registration failure. Contact the help desk
    to resolve any of these issues.
17. The Submission Receipt page reminds users that they will not receive an e-mail confirmation and that attestation information must be submitted in order to qualify for an incentive payment. **Print the Submission Receipt page** by selecting the “Print” button at the bottom of the page. Select the “Return to Home” button to proceed.
18. A registration must be Active in order to proceed with Attestation and Payment. If any changes need to be made to the registration, the user would select the Modify link and navigate back to the topics page. The

registration can also be cancelled, which would end the Eligible Professional's participation in the EHR Incentive Program.

19. Selecting the Status tab navigates the user to the Status Summary page. The Select link navigates to the Status Detail page which displays all of the registration information in one location. The Additional Information link expands to display more registration information and the status of validations that are performed during submission.

Q & A from the listeners (always the best part!)

Q: Do you have to have paid for an EHR to receive the money? Can you use a Free EHR and still receive the incentive money?

A: Yes, you can use a free EHR and still receive the incentive money. The incentive money is to assist EPs implement EHRs and is not intended to be used only to purchase the software. Remember that the EHR must be certified by one of the certifying bodies and must be certified for ambulatory care.

Q: Is there a certain amount of time after registering that an EP must attest for Medicaid?

A: Once an EP registers, there is no deadline for attesting. Once an EP has attested, payment will be received in 45 days or less.

Q: Is the denominator for the meaningful use measures all patients that an EP sees, or just all Medicare or Medicaid patients seen during a specific period?

A: The denominator is all patients that the EP sees during the applicable period.

Q: Are radiologists eligible?

A: Yes. The radiologist must use a certified ambulatory care EHR. There is no guideline as to where the information going into the EMR comes from, with the exception of the CPOE measure. Many radiologists have expressed concerns as they do not actually "see" patients – CMS will be addressing this in the future.

Q: Where does the certification number needed for the EHR Incentive Program registration come from?

A: The certification number comes from the **CHPL website.** Get the EHR Vendor's certification number, enter that number into the CHPL site and a registration/attestation number will be provided from the CHPL program to enter into the registration/certification program.

nursing home visits

Q: Is attestation the last step after completing the 90-day reporting period and collecting the data for the Medicare meaningful use program?

A: Yes.

Q: Do visits count if an EP sees patients in nursing homes?

A. Nursing home visits can count if a certified ambulatory EHR is being used, for instance if the EP carries a laptop with him, or if the visit information is later entered into the EP's EHR.

Q: Can an administrator or other third party complete the registration and attestation?

A: Yes, if the third party goes through the Identity and Authority Management system, they can register and attest. The system will ask for the third party's social security number as they will be legally attesting to the information entered.

Q: What is the latest 90-day period an EP can use a certified EHR to receive an incentive payment for 2011?

A: October 1, 2011 – December 31, 2011 is the latest 90-day period. EPs must start using a certified EHR by October 1, 2011 and must demonstrate meaningful use by providing data via the attestation process before 60 days after the close of the 2011 calendar year.

Q: What if due to the EP's specialty none of the meaningful use measures can be met?

A: The EP must exhaust all core, alternate and menu measures by answering "0", exhausting all 38 of the measures by attesting "0" to all 38.

Q: If state does not accept any electronic submission of public health information, is the EP excluded from having to meet this requirement?

A: Yes.

Resources:

EHR Information Center

Hours of Operation: 7:30 a.m. – 6:30 p.m. (Central Time)
Monday through Friday, except federal holidays.
1-888-734-6433 (primary number) or 888-734-6563 (TTY number)

The Dog Days of PECOS: CMS Publishes the Short Form (Paper) for PECOS, plus Consultant David Zetter Walks You Through It Online

NOTE: The date has been ~~changed to July 5, 2011~~ has been delayed indefinitely.

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Many managers have told me they know their providers are in PECOS but they're not on the list OR they never enrolled their providers but they are on the list OR they've sent their paperwork and have not heard back for 2, 4, 6 weeks – should they be worried? The CMS website says "It is possible that it could take 45-60 days, sometimes longer, for Medicare enrollment contractors to process enrollment applications," so I guess we all need to chill out a little.

The massive undertaking of qualifying every single healthcare professional who refers/orders or provides medical services to Medicare patients in order to sift out those who would lie about providing goods and services is fraught with confusion, miscommunication and misunderstanding. That's okay, though, because **CMS says no checks for services or goods will be withheld due to providers not being listed in PECOS, at this time.** They know it's a mess and it will take quite a while to get everyone straightened out, on the list and able to get checks from CMS if and only if their name is on the list.

Below is the CMS fact sheet published last week.

Image via Wikipedia

Medicare Enrollment Guidance for Physicians that Infrequently Receive Reimbursement from the Medicare Program

Traditionally, most physicians have enrolled in the Medicare program to furnish covered services to Medicare beneficiaries. However, with the implementation of Section 6405 of the Affordable Care Act, some physicians will need to enroll in the Medicare program for the sole purpose of certifying or ordering services for Medicare beneficiaries. These physicians do not send claims to a Medicare contractor for the services they furnish.

In the process of implementing the provisions contained in the Affordable Care Act, we have become aware of several unique enrollment issues for certain types of physicians or practitioners. Specifically, we have modified the process of enrollment to accommodate the special circumstances of the following individual physicians and practitioners:

- Physicians employed by the Department of Veterans Affairs
- Physicians employed by the Public Health Service
- Physicians employed by the Department of Defense Tricare program
- Physicians employed by Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) or Critical Access Hospitals (CAHs)
- Physicians in a Fellowship
- Dentists, including oral surgeons

This document provides guidance to those practitioners.

Q: How can I verify whether I am already enrolled in PECOS?

A: If a physician is concerned or uncertain about whether s/he is actually enrolled in the Provider Enrollment, Chain and Ownership System (PECOS), s/he can review the Ordering and Referring file found in the download section of the "OrderingReferringReport" tab (**click here**) on the Medicare Provider and Supplier Web Site.

Providers and suppliers can check with the ordering or referring physician to see if the physician is currently seeing Medicare patients and the physician's claims are being paid. Until we advise otherwise, your orders and referrals will not be rejected due to the lack of an approved enrollment record in PECOS.

Q: I am a physician employed by the Department of Veterans Affairs, Department of Defense Tricare program, by the Public Health Service, an FQHC, an RHC, or a CAH. Do I need to enroll in PECOS to order and refer items or services for Medicare beneficiaries?

A: Yes, but we have abbreviated the enrollment process and documents for physicians employed by the Department of Veterans Affairs, the Public Health Service, the Department of Defense Tricare program, an FQHC, an RHC, or a CAH. However, because this is a unique solution to enrollment for a specific set of physicians, our systems will not accommodate the abbreviated forms on-line. Therefore, any physician employed by the Department of Veterans Affairs, the Public Health

Service, the Department of Defense Tricare program, an FQHC, an RHC, or a CAH, who is not already enrolled in PECOS, must use the paper enrollment application process
and do the following:

Complete the following sections of the paper CMS-855I, "Medicare Enrollment Application for Physicians and Non-Physician Practitioners" and mail the completed form to the designated Medicare enrollment contractor:

- *Section 1 Basic Information (they would be a new enrollee)*
- *Section 2 Identifying Information (section 2A, 2B, 2D and if appropriate 2H and 2K)*
- *Section 3 Final Adverse Actions/Convictions*
- *Section 4C/4E Practice Location Information (same as section 2B)*
- *Section 13 Contact Person*
- *Section 15 Certification Statement (must be signed and dated""**blue ink recommended)***
- *Section 17 Supporting Documentation (**cover letter** stating the provider is only enrolling to order and refer services to a beneficiary)*

Note: Physicians who are employed by the Department of Veterans Affairs, the Public Health Service, the Department of Defense Tricare program, an RHC, FQHC, or CAH are not required to include the Electronic Funds Authorization Agreement (CMS-588) or the Medicare Physician and Supplier Agreement (CMS-460) with the enrollment form.

Q: I am a physician in a fellowship program. Do I need to enroll in PECOS?

A: If you are a physician in a fellowship, and licensed in the State, you can enroll in Medicare for the sole purpose of ordering or referring items or services for Medicare

beneficiaries. To enroll as a “referring and ordering physician-only” you would need to complete the abbreviated enrollment application form in the same way as other physicians (VA, DoD, PHS, FQHC, RHC CAH) who are enrolling to order and refer only (see previous question.) If you elect to enroll to order and refer only, you would not be enrolled in Medicare for the purpose of providing Medicare services to Medicare beneficiaries. In order to provide covered services to Medicare beneficiaries, a physician would need to complete the full enrollment application either on-line or in hard copy.

Q: I am an Oral Surgeon or Dentist. How do I Enroll in PECOS?

A: Dentists, including oral surgeons, must enroll in the Medicare program to receive reimbursement for services furnished to Medicare beneficiaries or to order covered items or services for Medicare beneficiaries. Oral surgeons would complete the same paper forms, or on-line application, as any other practitioner enrolling in PECOS.
If you elect to enroll as a “referring and ordering physician-only”, you would need to complete the abbreviated enrollment application form in the same way as other physicians (VA, DoD, PHS, FQHC, RHC CAH) who are enrolling to order and refer only (see previous two questions.) If you elect to enroll to order and refer only, you would not be enrolled in Medicare for the purpose of providing Medicare services to Medicare beneficiaries.

In order to provide covered services to Medicare beneficiaries, a dentist, including oral surgeons, would need to complete the full enrollment application either on-line or in hard copy.

Note: In completing the enrollment application portion dealing with specialty, oral surgeons would check the “oral

surgery (dentist only)" box found in section 2 of the Medicare enrollment application and any other dentist would check the box titled, "Undefined Physician Type" and specify that they are a dentist in the space provided. In the near future, we will revise the Medicare enrollment application to add "Dentist" as a physician specialty.

Internet-based PECOS

Physicians and practitioners who are employed by the Department of Veterans Affairs, the Defense Department, the Public Health Service, an RHC, FQHC, or CAH **must complete the paper enrollment application that has been modified and shortened to accommodate the special situation of these professionals.** All other physicians and practitioners who furnish services to Medicare beneficiaries must enroll in the Medicare program to receive reimbursement and order/refer in the Medicare program. For those physicians and practitioners using the on-line process, we have developed a document that will help you through the PECOS enrollment process. It will be easier to complete the process if you review this document before you begin the enrollment process.

- The document titled, "Internet-based PECOS – Getting Started Guide for Physicians and Non-Physician Practitioners" can be found **here.**
- Although you are permitted to complete your enrollment application in hard copy, it will be easier and quicker if you use the Internet-based Provider Enrollment, Chain and Ownership System (PECOS) to complete the Medicare enrollment process. The Internet-based PECOS application is completed via the web **here.**
- After submitting an enrollment application via Internet-based PECOS, you must:
    - Print, sign and date (blue ink recommend) the Certification Statement(s), and
    - Mail the Certification Statement(s) and applicable

supporting documentation to the designated Medicare contractor (no later than 7 days after you complete the online portion.)

- NOTE: The Medicare contractor will not be able to begin to process your enrollment application until it receives a signed and dated Certification Statement.

Additional Medicare Enrollment Information

To ask a provider enrollment question, contact the Medicare contractor for your State. Medicare provider enrollment contact information for each State can be found **here.**

To report Internet-based PECOS navigation, access, or printing problem with Internet-based PECOS, contact the EUS Help Desk at 1-866-484-8049 or send an e-mail to the EUS Help Desk to EUSSupport@cgi.com

For additional information regarding the Medicare enrollment process, visit the website **here.** Of course, if you have any additional questions about the Medicare enrollment process, you can contact the designated Medicare contractor for your state.

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If you haven't started yet but plan to use the online process to enroll your providers or yourself, here's a really excellent SlideShare presentation by David Zetter that steps you through the enrollment process by showing screen shots of each step. You can contact David Zetter **here**.

PECOS Enrollment Process

ARRA Eligible Providers: Who Is Eligible to Receive Stimulus Money and How Much is Available Per Provider?

Note: read my latest post on getting the EHR Incentives here.

Medicare Definition of Eligible Provider (EP)

For Medicare, physicians and some hospitals are eligible providers. “Physicians” includes doctors of medicine (MD) or osteopathy (DO), dentists or dental surgeons (DDS or DMD), podiatric medicine (DPM), and optometry (OD) and chiropractors (DC).

For providers, their annual payment will be equal to 75 percent of Medicare allowable charges for covered services in a year, not to exceed the incentives in the table below. Payments will be made as additions to claims payments.

Hospitals include quick-care hospitals (subsection-d) and critical access hospitals and only includes hospitals in the 50 States or the District of Columbia.

Medicaid Definition of Eligible Provider (EP)

Medicaid takes the Medicare definition of eligible providers (physicians) and adds nurse practitioners, certified nurse midwives and physician assistants, however, physician assistants are only eligible when they are employed at a federally qualified health center (FQHC) or rural health

clinic (RHC) that is led by a Physician Assistant. Eligible hospitals include quick care hospitals and children's hospitals.

At minimum, 30 percent of an EP's patient encounters must be attributable to Medicaid over any continuous 90-day period within the most recent calendar year. For pediatricians, however, this threshold is lowered to 20 percent.

The first year of payment the Medicaid provider must demonstrate that he is engaged in efforts to adopt, implement, or upgrade certified EHR technology. For years of payment after year 1, the Medicaid provider must demonstrate meaningful use of certified EHR technology.

Change 1:

The definition of "hospital-based physician" was recently clarified to include physicians working in hospital outpatient clinics (employed physicians) as opposed to the inpatient units, surgery suites or emergency departments. This still excludes pathologists, anesthesiologists, ER physicians, hospitalists and others who see most of their patients in the ER as outpatients or as hospital inpatients.

Possible Change 2:

The Health Information Technology Extension for Behavioral Health Services Act of 2010 (HR 5040) is a bill in the US Congress originating in the House of Representatives that would amend the Public Health Service Act and the Social Security Act to extend health information technology assistance eligibility to behavioral health, mental health, and substance abuse professionals and facilities, and for other purposes. You can track the bill **here.**

For more information on stimulus money for meaningful use of

an EMR, read my post **here.**